ST. JOHN'S UNIVERSITY

PHYSICAL EXAMINATIONS

(To be completed by physician or healthcare provider.)

STUDENT HEALTH SERVICES

Queens Campus
DaSilva Hall
8000 Utopia Parkway
Queens, NY 11439
Tel 718-990-6360
Fax 718-990-2368
stjohns.edu

Please complete and fax, mail, or return in person to the Health Services Center at the Queens campus by Monday, May 14, 2018.

Student Name:_____ Date of Birth:_____

Student ID #: X_____ Gender: ☐ Male ☐ Female

Campus where you are enrolled (check one): ☐ Queens ☐ Manhattan ☐ Staten Island ☐ Online Learning

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: _____ Right: _____ Left: _____ Corrected: Right: _____ Left: _____

For Health Sciences students only:

Color Vision Screening Normal _____ Abnormal _____

Urinalysis Result Normal _____ Abnormal _____ Date: _____

Blood Count HCT: _____ HGB: _____ Date: _____

	Normal	Abnormal		Normal	Abnormal
Head, neck, face, and scalp	_____	_____	Abdomen	_____	_____
Nose and sinuses	_____	_____	Endocrine System	_____	_____
Mouth, teeth, gingival	_____	_____	Extremities	_____	_____
Ears	_____	_____	Reflexes	_____	_____
Eyes	_____	_____	Musculoskeletal	_____	_____
Lungs, chest, and breasts	_____	_____	Lymphatic	_____	_____
Heart	_____	_____	Neurologic	_____	_____
Vascular	_____	_____	Genital/Urinary	_____	_____

In your judgment, is there any reason why physical activities would be contradicted? ☐ Yes ☐ No

If yes, explain: _____

Family history (relevant health problems): _____

TB SCREENING

Tuberculin Skin Test (within six months of exam): Date Planted ___/___/___ Date Read ___/___/___

Result: ☐ Positive ☐ Negative _____mm induration

Pharm.D. Students Only two-step testing necessary: Date Planted ___/___/___ Date Read___/___/___

Result: ☐ Positive ☐ Negative _____mm induration

or QTF TB Gold Test Date ___/___/___ **Result:** ☐ Positive ☐ Negative ***Attach QTF Lab Results***

***If QTF or PPD Test Positive, Chest X-Ray Required:** Date ___/___/___ Result: ☐ Positive ☐ Negative

VACCINE RECORD (if blood titers drawn, please attach lab results)

Tetanus-Diphtheria Booster *(within 10 years):* Date ___/___/___ Tdap Date ___/___/___

Varicella Vaccine: Dose 1 ___/___/___ Dose 2 ___/___/___ or Disease Date ___/___/___

Hepatitis B Vaccine *(recommended)*: Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 ___/___/___

Meningococcal Vaccine *(recommended after 16th birthday)*: Date ___/___/___

or Refused ☐ *Attach Meningitis Response Form*

MMR (required by NYS Law): Dose 1 ___/___/___ Dose 2 ___/___/___

Polio series completed: ☐ Yes ☐ No

Physician's Name (Print): _____

Signature: _____ Exam Date: ___/___/___

License Number: _____ Physician Stamp: _____

or attach Rx with signature

The information contained on this form is accessible only to the professional health staff of Student Health Services and will not be released without the written authorization of the student or pursuant to a lawfully issued subpoena. The authority to request this information is found in Section 355 of the Educational Law.